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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00394

400

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Pine Frederick</i>		<i>21 days</i>		TOWN <i>Solomons</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co. Hospital</i>				STREET ADDRESS (If rural give location) <i>/</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Mary Gertrude Brooks</i>				<i>Jan 10 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>W</i>	<i>married</i>	<i>Oct. 8, 1885</i>	<i>70</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housework</i>			<i>None</i>	<i>Solomons Maryland</i>		<i>U.S.A</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John B. Harten</i>				<i>Drucilla Jane Elliott</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>No</i>		<i>Solomons, Md</i> <i>John B. Brooks (Husband)</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
157X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>Carcinomatous</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
<i>Cx of Head of pancreas</i>							
(C) DUE TO							
<i>x liver</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/30</i> <i>1955</i> to <i>1/10</i> <i>1956</i>, that I last saw the deceased alive on <i>1/10</i> <i>1956</i>, and that death occurred at <i>12</i> <i>M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. E. Sullivan</i>				ADDRESS (Street, city, town, state) <i>Solomons, Maryland</i>		DATE SIGNED <i>1/10</i>	
				M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Jan. 12, 1956</i>		<i>Solomons Methodist</i>		<i>Solomons, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>DATE 1-11-56</i>		<i>H. W. Ward</i>		<i>A. A. Hackness & Son - Mutual, Md.</i>			

CERTIFICATE OF DEATH

WILLIAM D. M. M.

1. USUAL RESIDENCE (NUMBER OF HOUSEHOLD)

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF NOTARY

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF CLERK

22. SIGNATURE OF ASSISTANT CLERK

23. SIGNATURE OF RECEPTION CLERK

24. SIGNATURE OF RECORDS CLERK

25. SIGNATURE OF INDEXING CLERK

26. SIGNATURE OF FILE CLERK

27. SIGNATURE OF DISTRIBUTION CLERK

28. SIGNATURE OF MAIL CLERK

29. SIGNATURE OF TELETYPE CLERK

30. SIGNATURE OF TELEPHONE CLERK

31. SIGNATURE OF STENOGRAPHER

32. SIGNATURE OF CLERICAL ASSISTANT

33. SIGNATURE OF RECEPTIONIST

34. SIGNATURE OF MAIL ROOM CLERK

35. SIGNATURE OF TELETYPE ROOM CLERK

36. SIGNATURE OF TELEPHONE ROOM CLERK

37. SIGNATURE OF STENOGRAPHIC CLERK

38. SIGNATURE OF CLERICAL ASSISTANT

39. SIGNATURE OF RECEPTIONIST

40. SIGNATURE OF MAIL ROOM CLERK

41. SIGNATURE OF TELETYPE ROOM CLERK

42. SIGNATURE OF TELEPHONE ROOM CLERK

43. SIGNATURE OF STENOGRAPHIC CLERK

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00395

401

CERTIFICATE OF DEATH

Reg. Dist. No. 52

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY OR TOWN <u>Prince Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County H</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Calvert</u> CITY OR TOWN <u>Stuart Point</u> STREET ADDRESS <u>MD</u>	
3. NAME OF DECEASED (Type or Print) <u>Betty Lou</u> (First) <u>Hall</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>1</u> (Month) <u>28</u> (Day) <u>1956</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Mar 27, 53</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>10</u> yrs. <u>10</u> Months <u>10</u> Days
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Hall</u>		14. MOTHER'S MAIDEN NAME <u>Jena Mae Hannan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Mother, Mrs Ed Hall</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>474X</u> IMMEDIATE CAUSE (A) <u>Cardiac failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Croup</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>It had difficulty breathing for 12 hrs</u>			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., M., from the causes and on the date stated above.			
SIGNATURE <u>H W Ward</u>		ADDRESS (Street, city, town, state) <u>10 W E</u>	
DATE SIGNED <u>1/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan 30 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Harmony</u>	LOCATION (City, town, or county) <u>Mt Harmony MD</u>
24. REC'D BY REGISTRAR <u>Grace L. Hutchins</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>N. Harry Hutchings</u>	ADDRESS
DATE <u>1/30/56</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. DEATH DATE

8. DEATH PLACE

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. MEDICAL CERTIFICATION

12. SIGNATURE

13. TITLE

14. ADDRESS

15. CITY

16. STATE

17. ZIP CODE

18. TELEPHONE

19. HOSPITAL

20. PHYSICIAN

21. NURSE

22. CORONER

23. JUDGE

24. CLERK

25. OTHER

26. SIGNATURE

27. TITLE

28. ADDRESS

29. CITY

30. STATE

31. ZIP CODE

32. TELEPHONE

33. HOSPITAL

34. PHYSICIAN

35. NURSE

36. CORONER

37. JUDGE

38. CLERK

39. OTHER

40. SIGNATURE

41. TITLE

42. ADDRESS

43. CITY

44. STATE

45. ZIP CODE

46. TELEPHONE

47. HOSPITAL

48. PHYSICIAN

49. NURSE

50. CORONER

51. JUDGE

52. CLERK

53. OTHER

54. SIGNATURE

55. TITLE

56. ADDRESS

57. CITY

58. STATE

59. ZIP CODE

60. TELEPHONE

61. HOSPITAL

62. PHYSICIAN

63. NURSE

64. CORONER

65. JUDGE

66. CLERK

67. OTHER

68. SIGNATURE

69. TITLE

70. ADDRESS

71. CITY

72. STATE

73. ZIP CODE

74. TELEPHONE

75. HOSPITAL

76. PHYSICIAN

77. NURSE

78. CORONER

79. JUDGE

80. CLERK

81. OTHER

82. SIGNATURE

83. TITLE

84. ADDRESS

85. CITY

86. STATE

87. ZIP CODE

88. TELEPHONE

89. HOSPITAL

90. PHYSICIAN

91. NURSE

92. CORONER

93. JUDGE

94. CLERK

95. OTHER

96. SIGNATURE

97. TITLE

98. ADDRESS

99. CITY

100. STATE

101. ZIP CODE

102. TELEPHONE

103. HOSPITAL

104. PHYSICIAN

105. NURSE

106. CORONER

107. JUDGE

108. CLERK

109. OTHER

110. SIGNATURE

111. TITLE

112. ADDRESS

113. CITY

114. STATE

115. ZIP CODE

116. TELEPHONE

117. HOSPITAL

118. PHYSICIAN

119. NURSE

120. CORONER

121. JUDGE

122. CLERK

123. OTHER

124. SIGNATURE

125. TITLE

126. ADDRESS

127. CITY

128. STATE

129. ZIP CODE

130. TELEPHONE

131. HOSPITAL

132. PHYSICIAN

133. NURSE

134. CORONER

135. JUDGE

136. CLERK

137. OTHER

138. SIGNATURE

139. TITLE

140. ADDRESS

141. CITY

142. STATE

143. ZIP CODE

144. TELEPHONE

145. HOSPITAL

146. PHYSICIAN

147. NURSE

148. CORONER

149. JUDGE

150. CLERK

151. OTHER

152. SIGNATURE

153. TITLE

154. ADDRESS

155. CITY

156. STATE

157. ZIP CODE

158. TELEPHONE

159. HOSPITAL

160. PHYSICIAN

161. NURSE

162. CORONER

163. JUDGE

164. CLERK

165. OTHER

166. SIGNATURE

167. TITLE

168. ADDRESS

169. CITY

170. STATE

171. ZIP CODE

172. TELEPHONE

173. HOSPITAL

174. PHYSICIAN

175. NURSE

176. CORONER

177. JUDGE

178. CLERK

179. OTHER

180. SIGNATURE

181. TITLE

182. ADDRESS

183. CITY

184. STATE

185. ZIP CODE

186. TELEPHONE

187. HOSPITAL

188. PHYSICIAN

189. NURSE

190. CORONER

191. JUDGE

192. CLERK

193. OTHER

194. SIGNATURE

195. TITLE

196. ADDRESS

197. CITY

198. STATE

199. ZIP CODE

200. TELEPHONE

201. HOSPITAL

202. PHYSICIAN

203. NURSE

204. CORONER

205. JUDGE

206. CLERK

207. OTHER

208. SIGNATURE

209. TITLE

210. ADDRESS

211. CITY

212. STATE

213. ZIP CODE

214. TELEPHONE

215. HOSPITAL

216. PHYSICIAN

217. NURSE

218. CORONER

219. JUDGE

220. CLERK

221. OTHER

222. SIGNATURE

223. TITLE

224. ADDRESS

225. CITY

226. STATE

227. ZIP CODE

228. TELEPHONE

229. HOSPITAL

230. PHYSICIAN

231. NURSE

232. CORONER

233. JUDGE

234. CLERK

235. OTHER

236. SIGNATURE

237. TITLE

238. ADDRESS

239. CITY

240. STATE

241. ZIP CODE

242. TELEPHONE

243. HOSPITAL

244. PHYSICIAN

245. NURSE

246. CORONER

247. JUDGE

248. CLERK

249. OTHER

250. SIGNATURE

251. TITLE

252. ADDRESS

253. CITY

254. STATE

255. ZIP CODE

256. TELEPHONE

257. HOSPITAL

258. PHYSICIAN

259. NURSE

260. CORONER

261. JUDGE

262. CLERK

263. OTHER

264. SIGNATURE

265. TITLE

266. ADDRESS

267. CITY

268. STATE

269. ZIP CODE

270. TELEPHONE

271. HOSPITAL

272. PHYSICIAN

273. NURSE

274. CORONER

275. JUDGE

276.

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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00396

402

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
<u>Prince Frederick</u>		<u>3 days</u>		<u>Dowell</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>County Hosp.</u>				<u>X</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Vincent</u>		(Middle)		(Last) <u>Johnson</u>		(Month) (Day) (Year)	
(Type or Print)						<u>Jan. 26 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>colored</u>	<u>single</u>	<u>August 21, 1902</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Dowell, Md</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert J. Johnson</u>				<u>Maggie Bice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension c.v.d.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-26</u> , 19 <u>56</u> , to <u>1-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-26</u> , 19 <u>56</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>R. E. Sewell</u> M.D.				ADDRESS (Street, city, town, state) <u>Prince Frederick, Md</u>			
DATE SIGNED <u>1/26/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>1-29-56</u>		<u>54 Johns</u>		<u>Prinsely</u>		<u>md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-27-56</u>		<u>H. W. Ward</u>		<u>P. E. Sewell</u>		<u>Prince Frederick, Md</u>	
DATE							

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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00397

403

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Chesapeake Beach</u>				TOWN <u>West Ches. Beach</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louis</u> (Middle) (Last) <u>Stepney.</u>				(Month) (Day) (Year) <u>1 - 28 - 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March, 15.</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Tenant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Stepney</u>				14. MOTHER'S MAIDEN NAME <u>P</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-28-9239</u>		17. INFORMANT & ADDRESS <u>Maude Stepney, West Ches. Beach, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/10</u> , 19 <u>56</u> , to <u>1/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>56</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. W. Ward</u>				ADDRESS (Street, city, town, state) <u>Huntingtown Calvert Md</u>		DATE SIGNED <u>1/30/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1-31-56</u>		NAME OF CEMETERY OR CREMATORY <u>St-Edmonds</u>		LOCATION (City, town, or county) <u>Calvert Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.T. Sewell, Pr. Frederick Md</u>		ADDRESS	
DATE <u>1-30-56</u>							

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Item 9, Film G192 2-15-56 et

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY OR TOWN <u>Prince Frederick</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY OR TOWN <u>Dwings</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Eugene</u> (First) <u>Walton</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>January</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 23, 1892</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Walton</u>				14. MOTHER'S MAIDEN NAME <u>Stallings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Eugene Walton Dunkin</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension c.v.d. with</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral accident</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 29, 1956</u> , to <u>Jan 29, 1956</u> , that I last saw the deceased alive on <u>Jan 29, 1956</u> , and that death occurred at <u>7p</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Rd Williams</u>		M.D. <u>St Leonard</u>		DATE SIGNED <u>1/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Harmony</u>		LOCATION (City, town, or county) (State) <u>Mt Harmony Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Harry Hutchins Jr</u>		ADDRESS <u>Dwings Md.</u>	
DATE <u>1/31/56</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00399

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Olivet</u>				TOWN <u>Olivet</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Etnora Ellen</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Elmira Ellen Weems</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-9 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>8-28-1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas T. Weems</u>				14. MOTHER'S MAIDEN NAME <u>Annie Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Henrietta Thompson ind</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
782.4 IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Edema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M. from the causes and on the date stated above.							
SIGNATURE <u>Page Deth</u>				DATE SIGNED <u>1-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Eastern Chapel</u>		LOCATION (City, town, or county) (State) <u>Olivet, Md.</u>	
24. REC'D BY REGISTRAR <u>1-11-56</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u>		ADDRESS <u>Prince Fred. Trcl</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of undertaker

16. Signature of funeral home

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of final disposition

21. Signature of final disposition

22. Signature of final disposition

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